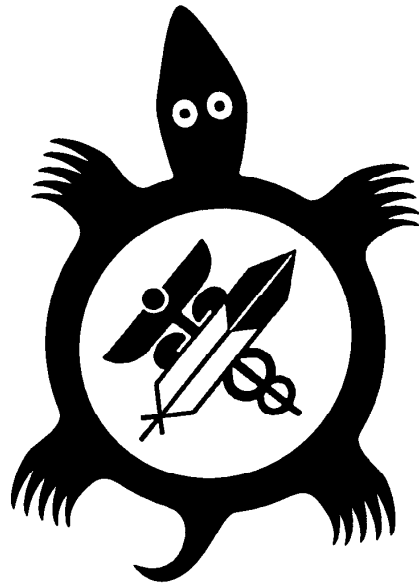

Public Health Support Workgroup Report

September 1, 1999



Final Report: Appendices A-J

The full Public Health Support Workgroup report will be available through the IHS Home Page on the Web at www.ihs.gov after December 1, 1999.

**PUBLIC HEALTH SUPPORT WORKGROUP
FINAL REPORT: APPENDICES A-J**

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APPENDIX A: Public Health Support Workgroup (PHSWG) Activity Chronology and Background

Chronology: The following table presents the key events and activities of the PHSWSG.

Date	Event	Participants/ Content/ Comments
July 1998	Invitation letter to PHSWG participants	
August 1998	Materials sent to participants for review	
August 25 & 26, 1998	First meeting	<ul style="list-style-type: none"> • adopted working definition of public health • adopted IOM model of three core functions and 10 essential services • overlaid 3 service delivery levels
September 1998	Surveys sent	See Appendix B for content and results.
September 17, 1998	Conference call	Updated current status and individual tasks
October 14 & 15, 1998	Second meeting	<ul style="list-style-type: none"> • Re-examined working definitions • Discussed residual for public health, and then for national level
December 10, 1998	IHLC presentation	Dr. Cullen presents IOM model and current status of workgroup
December 15-17, 1998	Third meeting	<ul style="list-style-type: none"> • Discussed the “residual” issue • Discussed ways to ensure PH needs get met in national, regional and local levels
January 5-7, 1999	NCCD	January 5, Dr. Cullen presents IOM model and current status of workgroup
January 21 & 22, 1999	PWHG subgroup presentation to IET	Cullen, Broderick, Kinney, Marquardt, Skupien 10 public health functions matrix and expertise spreadsheet (no numbers assigned yet)
February 17 & 18, 1999	PHSWG Meeting	<ul style="list-style-type: none"> • Formalize model and responsibilities • Formulation of work needed to complete charges • Reviewed models for the future (Portland, Tucson)
February 26, 1999	Internal Evaluation Team conference call with PHSWG	George Chiarchiaro, Bruce Chelikowsky, Kathy Annette, Victor Mosser, Dan Cesari, Clark Marquart, Rick Broderick, Terry Cullen
April 2, 1999	Draft Report sent to PHSWG members for review and comment	
April 21, 1999	ELG Presentation	Current status of report; needed work; concern about specific recommendations
May 4, 1999	Three Executive Council Presentation (CD, SUD, Nursing)	Current status of report; needed work; concern about specific recommendations
May 18, 1999	Draft report out for PHSWG comments	
May 26, 1999	PHSWG Conference Call for Final Review	Comments incorporated into final version.
June 1, 1999	Final Report to ELG	Executive Summary and Recommendations
June 16, 1999	Final Report to IHLC	Theresa Cullen presentation

APPENDIX A:

Public Health Support Workgroup (PHSWG) Activity Chronology and Background

Workgroup Process

In preparation for the first meeting, the following documents were sent to each Workgroup member:

- *Public Health in America*, APHA, Fall, 1994
- *The Future of Public Health*, Institute of Medicine (IOM), 1989
- ELG Draft, Information Packet on the Public Health Model, March 1997
- Four Councils Consensus Statement (National Councils of Service Unit Directors, Clinical Directors, and Nurses, and the Council of Chief Medical Officers)
- Final Report of Clinical and Public Health Operations Workgroup for IHDT (CPHOW), June 1995
- *Findings and Implications of a Survey Assessing IHS Area Office Public Health Capacity*, October 1997
- 1997 Billings Area Senior Executive Service Workplan (based on GPRA)
- Indian Health Design Team Report, November 1995
- *Blueprint for Headquarters* (Report to the Director, Indian Health Service), August 1998
- *Recommendations from the Information Systems Workgroup*, A Report to the Indian Health Leadership Council, September 1998 (??) [is this correct???
- Behavioral Health Workgroup Presentation, June 1998

A composite of the recommendations from these earlier efforts was developed, based on three main topics: programs, operations, and essential public health services. After reviewing this, the Workgroup was concerned that although many different groups had done much work on public health services, there was no apparent outcome or benefit derived from the previous attempts.

PHSWG members offered varied and occasionally conflicting possible reasons for this lack of decision making. The likely suspects were:

- money issues
- issues with public health approach
- reorganization issues
- leadership issues
- local infrastructure deficiencies

This discussion led to identifying significant Workgroup concerns:

- What is a definition of public health?
- What would it take to succeed with this charge?
- Define success for the PHSWG.
- What impact will the Blueprint Report have on the PHSWG work and product?
- What can the PHSWG do and not do?
- How are we different as *Indian* Public Health?

APPENDIX A:

Public Health Support Workgroup (PHSWG) Activity Chronology and Background

At the first meeting in August 1998, the Workgroup developed the initial framework by adopting the Institute of Medicine (IOM) model, consisting of three core public health functions (capacities) and 10 essential public health services. The PHSWG then overlaid this model with the three service delivery levels involved with Indian health care, the results of which are below. To facilitate looking at the Indian health system as a whole, we combined the first two charges to consider both IHS and tribal sites.

A survey was developed for local, Area and HQ representatives to provide an inventory of what, where and how Areas as well as urban sites obtain public health services. Other subgroup assignments were determined and presentations scheduled for the September conference call and the October meeting.

By the October meeting, the essential functions and responsibilities matrix was substantially complete. In December 1998, the Workgroup received an informal request from the Indian Health Leadership Council (IHLC) to amplify its original scope by making recommendations to the Internal Evaluation Team (IET) regarding any potentially residual public health functions within IHS Headquarters in a hypothetical 100% self-governance compacted environment.

APPENDIX B:

Inventory of Public Health Support for Indian Health Programs

SURVEY RESULTS

In order to learn more about the perceptions of individuals who work in Indian Health programs regarding the existing public health infrastructure at the various levels of the program, the Public Health Support workgroup developed 3 survey instruments to solicit the perspectives of a variety of individuals. The first survey targeted the local level and was sent to service unit directors, tribal health directors and urban health directors in each Area (one of each). The second survey was developed to obtain input from the area level and was sent to each Area Chief Medical Officer (CMO). The last survey was focused on the national level and was sent to staff within the Office of Public Health. All three surveys are included as attachments to this document.

Each survey posed questions about the adequacy of public health in the context of the essential public health services outlined by the DHHS Public Health Functions Steering Committee as listed below:

Essential Public Health Services:

1. Monitor health status to identify community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care
8. Assure a competent public health and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems

Survey 1 – Local level

Thirty-six survey instruments were mailed out; one to a service unit director, tribal health director, and urban program director from each area. Sixteen completed surveys were returned for a response rate of 44.4%. Four were from tribal programs, 5 from federal programs and 6 from urban programs.

- A majority of the respondents felt that overall capacity at the area level to provide essential public health services was either fair or good (10 of 16). Most comments to this questions indicated a major hindrance was insufficient funding.
 - Most felt there was adequate capacity to do monitoring (service #1), diagnosing (service #2), mobilizing (service #4), and assuring (service #8).
 - Most felt there was inadequate capacity to inform and educate (service # 3), develop policy (service #5), enforce laws (service #6), evaluate (service #9), and research (service #10).
 - For service #7 (linking people to required services), 6 felt capacity was adequate and 6 felt it was inadequate.
- Most respondents felt the capacity at the national level to provide essential public health services was poor (7 of 16). Many written comments indicated that headquarters no longer has the capacity to provide these services.

APPENDIX B:

Inventory of Public Health Support for Indian Health Programs

- At the national level a majority of respondents felt that capacity was inadequate to do any of the essential services.
- The most commonly identified public health service that the respondents indicated they currently do not have access to were #2 (diagnosis), #5 (develop policy), #1 (monitoring), #4 (mobilizing partnerships), #7 (linking people to services), and #9 (evaluating services).
- The most commonly identified public health service that respondents indicated they will most need in the next 3-5 years were #8 (assuring a competent workforce), 9 (evaluating services), and 10 (research).
- Five respondents were aware of alternative sources of public health services and 6 were not aware of alternative sources.

Survey 2 – Regional level

Surveys were sent to each of the 12 Area Chief Medical Officers (some CMOs in turn gave the instrument to other staff). Fourteen completed surveys were returned (116% response rate) and all areas were represented.

- Most respondents (7) felt the capacity in their area to for essential public health services was good. Comments to this question indicated that most felt their area was holding its own but capacity was in jeopardy of being degraded.
 - Most felt there was adequate capacity to do services #1 (monitor), #2 (diagnose), #3 (inform and educate), #4 (mobilize), #5 (develop plans), and #7 (link people to services).
 - Most felt there was inadequate capacity to do services #6 (enforce laws), #9 (evaluate services), and #10 (research).
 - For service #8 (assure a competent work force), 5 felt capacity was adequate and 5 felt it was inadequate.
- The most commonly identified public health service that the respondents indicated health programs in their area do not have access to were #1 (monitoring), #6 (enforcing laws), and #10 (research).
- The most commonly identified public health service that respondents indicated health programs in their area will most need in the next 3-5 years were #1 (monitoring), #4 (mobilizing), and #8 (assuring a competent workforce).
- Overall comments generally, 1) urged that the agency place more emphasis on public health, 2) indicated the need for additional resources to support public health, 3) suggested increasing the tribal role in public health services, 4) suggested educating others about the importance of these services, and 5) stressed the importance of partnering to carry out these services.
- The majority of respondents were aware of alternative sources of public health services but indicated there were obstacles to obtaining services from these alternative sources.

Survey 3 – National level

Survey instruments were distributed to 20 members of the Office of Public Health staff in IHS headquarters. Fifteen completed surveys were returned (75%) response rate.

- A majority of respondents (8) felt the capacity within headquarters to provide essential public health services to I/T/Us was either poor or fair. Comments to this question indicated that most felt headquarters capacity to provide public health services has been badly eroded.
 - Most felt there was adequate capacity to do services #2 (diagnosis).

APPENDIX B:

Inventory of Public Health Support for Indian Health Programs

- Most felt there was inadequate capacity to do services #1 (monitoring), #3 (inform and educate), #4 (mobilize), #5 (develop policy), #7 (link people to services), #8 (assure a competent workforce), #9 (evaluate), and #10 (research).
- For service #6 (enforce laws), 7 felt capacity was adequate and 7 felt it was inadequate.
- The most commonly identified public health service that the respondents indicated health programs do not have access to were #3 (inform and educate), #5 (develop policy), #8 (assure a competent workforce), and #9 (evaluate).
- The most commonly identified public health service that respondents indicated health programs will most need in the next 3-5 years were #4 (mobilize), #5 (develop policy), #7 (link people to services), #8 (assure a competent workforce) and #9 (evaluate).
- Overall comments generally indicated, 1) a need for expanded tribal capacity, 2) some need for centralization of some functions, and 3) the need for increased emphasis on public health.
- The majority of respondents were aware of alternative sources of public health services but indicated there were obstacles to obtaining services from these alternative sources.

Conclusions

- Public Health needs to be an area of emphasis within the agency
- Not enough resources are devoted to public health.
- When viewed collectively these surveys indicate that the respondent feel the capacity for obtaining public health services from the local and area levels are generally adequate while headquarters capacity was inadequate.
- All three surveys identified service #8 (assure a competent workforce) as among the most important that I/T/U programs will need access to over the next 3 to 5 years.

Limitation of results

These three instruments were distributed to a convenience sample of local health system managers (service unit directors, tribal health directors, and urban program directors), area health officials (area chief medical officers) and headquarters health staff. Because there are other perspectives which were not represented the results should not be generalized outside these groups. Sample size for all three surveys was small which also limits generalizability.

APPENDIX C: Public Health Responsibilities Matrix

ASSESSMENT

1. Monitor health status to identify community health problems.

Local	Regional	National
Provide appropriate access to local databases	Provide appropriate access to regional databases	Provide appropriate access to national database
Assess local needs and aggregate, assimilate, and analyze local data	Collect, aggregate, assimilate, and analyze regional data	Collect, aggregate, assimilate, and analyze national data
Interpret, communicate, and advocate	Interpret, communicate, and advocate	Interpret, communicate, and advocate
Promote participation in data collection – work with tribes and others in inventory of needs	Promote participation in data collection	Promote participation in data collection
Build competencies at local level	Build competencies at local level	Build competencies at regional and local levels
Collaborate with state and other local resources	Collaborate with state and other local resources	Collaborate with Federal and other national resources
Community assessment and planning		Develop uniform data and case definitions; standardize analytic approaches

2. Diagnose and investigate health problems and health hazards in the community.

Local	Regional	National
Help to ensure a safe and healthy institutional environment for staff, patients and others; assist tribes in investigation of environmental problems	Provide expertise in diagnosis and investigation of public health problems including assessment and remediation of environmental hazards	Provide expertise in diagnosis and investigation of public health problems including assessment and remediation of environmental hazards
Diagnosis and investigation of public health problems that span multiple communities	Diagnosis and investigation of public health problems that span multiple tribes/service units	Diagnosis and investigation of public health problems that span multiple regions
Collaboration, coordination, and control of response among Federal, state and county agencies	Collaboration, coordination, and control of response among Federal, state and county agencies	Collaboration, coordination, and control of response among Federal and state agencies
Develop community response teams	Support community response teams	Define standards for investigation
Respond to public health emergencies and disasters	Respond to public health emergencies and disasters	Respond to public health emergencies and disasters ; provide expertise in emergency response plan
Ensure and maintain cultural respect and sensitivity	Ensure and maintain cultural respect and sensitivity	Ensure and maintain cultural respect and sensitivity

APPENDIX C: Public Health Responsibilities Matrix

3. Inform, educate, empower people about health issues.

Local	Regional	National
Interpret, present, communicate to communities and others to advocate for local health needs	Interpret, present, communicate to States and others to advocate for regional health needs	Interpret, present, communicate to Congress, OMB and others to advocate for Indian health needs
Provide feedback from monitoring health status	Provide feedback from monitoring health status	Provide feedback from monitoring health status
Support education of local community leaders, including training for tribes on reporting needs	Support education of local community leaders	Support education of local community leaders
		Interpret national public health policy for providers at region and local levels

POLICY DEVELOPMENT

4. Mobilize community partnerships and coalitions to identify and solve health issues.

Local	Regional	National
Collaboration and coordination <ul style="list-style-type: none"> Federal agencies County agencies Universities Community colleges Professional Agencies 	Collaboration and coordination <ul style="list-style-type: none"> Interdepartmental partnerships Federal agencies State agencies Professional agencies Universities 	Collaboration and coordination <ul style="list-style-type: none"> Interdepartmental partnerships Federal agencies State agencies Universities Professional Agencies
Influence, advise policy at Federal/state/local levels	Influence, advise policy at state/county levels	Influence, advise policy at Federal/state/local levels
Identify potential partners	Identify potential partners	Identify potential partners
Develop local community partnerships and coalitions using accepted community mobilization strategies	Promote local community partnership and coalition development	Promote local community partnership and coalition development

5. Develop policies and plans that support individual and community health efforts.

Local	Regional	National
Collaborate with state and local organizations involved in public health to represent Indian health system concerns	Develop and make available sample policies/best practices regarding public health for local adoption	Develop and make available sample policies/best practices regarding public health for local adoption
Provide consultation and local involvement	Promote consultation and local involvement	Assure consultation and local involvement
Develop local health codes and policies that address local health concerns	Collaborate with state and regional organizations in public health to represent Indian health system concerns	Collaborate with national organizations in public health (i.e. ACIP, CDC, HUD, DOJ, EPA, FDA, etc.) to represent Indian health system concerns
Develop community health plans that incorporate resources; address priority health issues; establish short and long term goals and objectives; identify staffing and funding needs	In conjunction with I/T/U, insure strategic planning process regarding health issues	In conjunction with I/T/U, insure strategic planning process regarding health and safety issues
Lobby for health concerns at the local, state, and national levels		Advocate at all levels for tribes.

APPENDIX C: Public Health Responsibilities Matrix

POLICY DEVELOPMENT (continued)

6. Enforce laws and regulations that protect health and ensure safety.

Local	Regional	National
Provide legal advice regarding tribal laws, codes and regulations	Provide legal advice regarding Federal laws, codes and regulations	Provide legal advice regarding Federal laws, codes and regulations
Implement local health plans	Assist with the development of local codes (i.e. develop model codes); work with OSHA, research codes, reporting of infectious diseases, fluoridation, toxic substances, etc.	Assist with the development of local codes (i.e. develop model codes); work with OSHA, research codes, reporting of infectious diseases, fluoridation, toxic substances, etc.
Enforce Federal and tribal laws, codes and regulations		Disseminate information nationally to IHS and tribal staff

7. Link people to needed personal health services and assure the provision of health care.

Local	Regional	National
Develop agreements or networks with appropriate local and state entities to provide needed services not provided by Indian health	Develop agreements with appropriate entities to provide needed services not provided by Indian health	Develop agreements with other entities to provide needed services not provided by Indian health (i.e. VA, State AODA/MH services, public health, facilities, etc.)
Define gaps in services at the local level, including urban Indian issues, and advocate for appropriate changes (e.g. border health projects)	Define gaps in services at the regional level, and advocate for appropriate changes, and develop Tele-medicine capabilities	Define gaps in services in the Indian health system, and advocate for appropriate changes
Assure adequate biomedical and facility planning, design, and implementation to accommodate needs	Address multi-national issues regarding tribal enrollment, border health issues	Address multi-national issues regarding tribal enrollment, border health issues (e.g., injury prevention, water and sewer) and establish international relationships
Develop health services based on community needs to assure community support systems (i.e. school clinics, EMS, telephone, police, sanitation, outreach, home health, etc.)		

APPENDIX C: Public Health Responsibilities Matrix

ASSURANCE

8. Assure a competent public health and personal health care workforce.

Local	Regional	National
Establish and implement policies dealing with patient and employee satisfaction, grievances, and adverse incidents. Define staffing needs to maximize efficiencies.	Support and assist capacity of local level infrastructure	
Assure compliance with policies governing credentialing of licensed professionals. Assure mechanisms exist to obtain competent health care professionals to provide backup coverage. Establish on-going quality improvement system that includes peer review.	Shared development of appropriate clinical objectives	Develop policy governing credentialing and privileging of licensed professionals
	Arrange for and assist training of local staff, increasing public health expertise	Arrange for and coordinate national training opportunities that are unique for Indian public health care providers
Create relationships with local agencies, universities, community colleges, school systems to provide varying opportunities for career development, research, and subspecialty care.	Create regional relationships with agencies, universities, and states.	Create relationships with other agencies, universities, and foundations to provide varying opportunities for career development, research, and subspecialty care
Advocate for competitive salary structures and incentives for high quality staff	Advocate for competitive salary structures and incentives for high quality staff. Identify hard-to-fill positions because non-competitive salary structures.	Advocate for competitive salary structures and incentives for high quality staff
Promote leadership training that incorporates public health	Promote leadership training that incorporates public health	Promote leadership training that incorporates public health
Describe events that resulted in tort claims. Provide technical assistance to QRP.	Provide technical assistance to QRP.	Provide guidance to Dept. of Justice related to standards of care for tort claims (QRP).
Recruit competent staff on behalf of Indian health system. Develop competent human resource management departments.	Recruit competent staff on behalf of Indian health system	Recruit competent staff on behalf of Indian health system

APPENDIX C: Public Health Responsibilities Matrix

ASSESSMENT (continued)

9. Evaluate effectiveness, accessibility, and quality of personal and public health services.

Local	Regional	National
Assure community input for open discussion and feedback with health staff	Assure the “Indian voice” in developing goals for Healthy People 2010	Assure the “Indian voice” in developing goals for Healthy People 2010
Establish on-going evaluations of unmet needs and access to care.	Facilitate development of accurate regional tribal specific data	Develop national and regional data for comparison
Evaluate outcomes and incorporate results into health planning efforts.	Disseminate regional data back to tribes	Assemble national outcome data (i.e. GPRA, ORYX, HP 2000, HP 2010, HEDIS, Narrowing the Gap, etc)
Establish on-going facility and community-wide quality improvement approaches that include peer review and patient satisfaction surveys.	Facilitate exchange of local programs that will help all achieve and maintain accreditation	
	Cooperatively setting the desired GPRA measures with the tribes	Negotiate GPRA outcome measures with high authorities
Establish mechanism to incorporate improvements into public health programs	Modify review process to meet regional and local needs	Develop policy for review of public health programs

10. Research for new insights and innovative solutions to health problems.

Local	Regional	National
Seek and attract funding by collaborating with researchers to support research that would be helpful to American Indians/ Alaska Native people	Seek and attract funding by collaborating with researchers to support research that would be helpful to American Indian/Alaska Native people	Seek and attract funding by collaborating with researchers to support research that would be helpful to American Indians/ Alaska Native people
Assure that tribal desires with respect to data ownership, return of research findings, etc., are carried out.	Assure respect for tribes’ perspectives with all research involving their members.	Establish on-going policies that include tribal review and approval to maximize benefits and minimize risks of research to individuals, communities and tribes
Participate in tribally approved research.	Help protect human subjects while encouraging useful research	Promote positive, strength-based research

APPENDIX D:

Data Needs For Environmental Health Services And Sanitation Facilities Construction

Environmental health:

- Rate of hospitalizations for unintentional injuries and poisonings.
- Rate of hospitalizations resulting from domestic violence and suicide attempts.
- Number of successful suicide attempts.
- Rate of hospitalizations for asthma among children ages 2-18.
- Years of Productive Life Lost per 1,000 population.
- Clinical visits attributable to hepatitis A and gastroenteritis, especially giardiasis, salmonellosis, shigellosis, and campylobacteriosis.
- Prevalence of children ages 5 and younger with blood lead levels that exceed 10 ug/dl.
- Prevalence of child safety restraint use.
- Number of community water systems that fail to meet SDWA requirements.

Data systems are currently available to track each of these indicators with the exception of child safety restraint use. However most Service Units have these data that could easily be input into existing tracking systems.

Sanitation Facilities: Data for the Sanitation Facilities Construction Program is maintained in three related databases. All of these may be updated by a personal computer- based system called STARS. The databases are described below:

Project Data System - PDS includes data about the important facts and milestones of each and every sanitation facilities project constructed under the authorization of PL 86-121. This information is used to track the progress of these projects, serving as an aid to Field, District, and Area project management and for Headquarters to provide information to Congress and others as requested.

PDS information is used to schedule, budget and evaluate general performance in the completion of projects. This information is used to perform Area program reviews. It is also used to determine relative workloads under the Resource Requirements Methodology.

Sanitation Deficiency System - SDS is a listing of all known sanitation deficiencies which are eligible for service under the PL 86-121 Sanitation Facilities Construction program for American Indian / Alaska Native people. SDS is used not only for internal program management and budget formulation, but also to provide a wide variety of information to members of Congress, OMB, GAO, EPA and various other Federal entities. The IHCA as amended Section 302 (g), requires that an annual report on Indian sanitation deficiencies be submitted to the President by the Secretary for transmittal to the Congress at the time the President submits the Federal budget to the Congress. Every identified project is listed in the report with specific information on estimated cost, homes served, etc.. The sanitation deficiencies data are updated annually to account for inflation, changing state and Federal regulations, to add new deficiencies, and to delete the deficiencies addressed by projects funded by IHS and others.

The SDS includes a Community Deficiency Profile which provides a summary of the number of homes in each community and what the types and extents of their deficiencies are.

Operation and Maintenance Data System - OMDS provides a source of background information on Indian owned and operated water, sewerage, solid waste and operation and maintenance organizations. This data system includes operational information on these sanitation facilities and organizations. The OMDS is used to monitor the status of operation and maintenance of sanitation facility systems.

The OMDS is also used to determine the degree to which Indian sanitation systems meet regulatory requirements, and to identify where further efforts are required. These needs are identified in SDS and include projects to develop tribal to operate and maintain existing facilities, and to provide for the long term replacement and improvement of current water, sewerage and solid waste systems. OMDS information can be useful in deciding how those goals are best achieved.

APPENDIX E:
Community Health Report Card
[COVER LETTER]

March 24, 1999

Addressee

X
X
X

Re: Final version of the Community Health Report Card

Dear xxx

The moment you have long awaited is here. Attached you will find the final version of the Indian Community Health Assessment indicators. The last round of voting got the list down to a total of twenty indicators. From that list Tony D'Angelo and I (as the lead co-conspirators in the project) hardened our hearts and pared the list down further to a total of fifteen indicators. In a couple of instances somewhat similar items were combined. So that you can see which ones were removed, I have also included the last working draft of the full list.

The further we reduced the list, the more painful it was to remove what were clearly good indicators by any standard. However, Tony and I both felt that in order to have a final product which could be adopted and utilized in its entirety by an "average Indian community," we wanted the total number of indicators to be in the range of ten to fifteen. We feel that the final set of fifteen indicators meets the most important criteria of being: (a) of vital interest to Indian communities, (b) comprehensive in scope, and (c) feasible to implement.

None of us on the workgroup ended up with all our "favorites" on the final list. Despite this, I ask each of you to review the final set, and ask yourself the following questions:

1. If adopted and implemented in its entirety, would this instrument provide a good proxy for the overall health status of the community?
2. If a community scored well or showed improvement over time on most or all of these indicators, would you feel confident that this reflected accurately a high level of health in the community?
3. If a community scored poorly or showed a deterioration over time on most or all of these indicators, would you feel confident that this reflected accurately a relatively poor level of health of the community?

APPENDIX E:
Community Health Report Card

4. Given that the final set of indicators covers only a couple of sentinel indicators in each of the major health disciplines (dental, environmental, mental, and medical health), are you nonetheless able to endorse and be an advocate for it as a tool for Indian communities.

Last, if in reviewing the final set you feel that there are one or two (no more than two!) indicators that were removed which you feel **ABSOLUTELY MUST BE ON THE FINAL SET**, please let me know real quick. Like within one week. Also let me know which ones you would then remove from the final set to keep the number at fifteen. If there is a consensus on changes, they will be incorporated before further distribution.

Following that, the FINAL set of indicators will be widely distributed for comment. Specifically, it will be presented in various forums such as meetings of the national and area Indian health boards, Community Health Representatives, Tribal Health Directors, Service Unit Directors, IHS Council of Associate and Area Directors (CAAD), Chief Medical Officers, National Council of Clinical Directors, IHS Research Conference, etc. Individuals who might be unhappy with parts or all of the instrument will be instructed to call Tony D'Angelo to air their grievances. Preferably at home in the evening so as not to disturb his workday.

Regarding implementation of the Community Health Report Card, Tony and I believe that it would be best to pilot it in a few Indian communities which express interest. Prior to implementation, all the details will be worked out on what exactly needs to be measured and how for each indicator. The methodology needs to be defined even for an indicator seemingly as straightforward as "High school graduation rate." A strategy will be developed to test, improve, maintain, and provide technical assistance in implementation of the instrument. In order to do this, we will be seeking three to five year funding to support a highly qualified and culturally competent project specialist and part time support staff. If you have suggestions on this, we'd like to hear them.

Finally, we never did fully agree on a name for this instrument. We started out with *Community Health Report Card*, but one member of the workgroup felt this might have negative connotations for many Indian folks. Another suggestion was *Community Health Profile*. I'm wondering if we shouldn't include the word "*Indian*" in the name somehow. Like maybe *Indian Specific Community Health Profile*. In any case, this is your final chance to vote for a name. Please indicate your preference from the list below.

In conclusion, Tony and I want to thank you for your help with this. We are moderately optimistic that some Indian communities will embrace this set of indicators as a way to assess their current state of health and measure their progress toward becoming healthier communities.

APPENDIX E:
Community Health Report Card

Sincerely,

Dee Robertson

cc:

Cheryle Kennedy, Executive Director, NPAIHB

=====

Vote for the name by circling one only:

1. Community Health Report Card
2. Community Health Profile
3. Indian Community Health Report Card
4. Indian Community Health Profile
5. Indian Specific Community Health Report Card
6. Indian Specific Community Health Profile
7. Other _____

Please sent your vote to:

Alicia Carson, Project Assistant
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APPENDIX E:
Community Health Report Card

**Assessing the Overall Health Status of American Indian
and Alaska Native Communities**

***** Draft #5 *****

prepared by Tony D'Angelo and Dee Robertson

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A. General Considerations

1. Brevity is good: We should limit the number of indicators to the minimum needed to give a good picture of the overall health of the community.
2. Indicators should be representative of their respective domains.
3. Collectively the indicators should:
 - Be comprehensive.
 - Include at least the medical, dental, social and educational domains.
 - Give a broad overview of the health of the community.

B. Criteria For Specific Health Status Indicators

Ideally each indicator should:

1. Be important and understandable to local communities.
2. Occur with sufficient frequency that trends can be observed.
3. Be a good proxy for health in the subject area.
4. Be capable of being measured reliably.
5. Not require complicated statistical analysis.
6. Be measurable by data that is readily available from existing data sources or is readily collectible.
7. Be comparable with other collected data.
8. Be free of cultural bias.
9. When possible, be stated in positive rather than negative terms.

C. Definitions

Unless otherwise implied or stated, the following age groups apply to the indicators listed below:

- Children2-11
- Adolescents12-18
- Adults.....19-64
- Seniors65 and older

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D. Specific Indicators by Category

Socio-demographic

1. High school graduation rate.
2. Proportion of children and adolescents ages 0-18 who live with (a) both, (b) one, or (c) neither natural parent.
3. Proportion of children grades 1-12 with more than 10 missed school days in the previous year.

Health status

4. Prevalence of diabetes all ages.
5. Rate of hospitalization (discharges per 1,000 population) for injuries and poisonings.
6. Rate of years of potential life lost per 1,000 population.
7. Prevalence of caries (tooth decay) in (a) 3-4 year old, and (b) 7-8 year old children.

Mental health and functional status

8. Average number of healthy days* for adults and seniors in the previous month.

Health risk factors and positive health behaviors

9. Prevalence of children ages 2-16 who have a weight associated with good health (i.e., a body mass index (BMI) <85th centile).
10. Percentage of pregnancies with prenatal care beginning in the first trimester.
11. Rate of women ages 18-65 with a Pap smear within the previous 24 months.
12. Prevalence of alcohol or other drug use among adolescents.
13. Prevalence of tobacco use among adolescents and adults.
14. Number and rate of confirmed cases of abuse and neglect in children and adolescents ages 0-15.

Environment

15. Presence of tribal ordinances requiring auto safety restraint use, and prevalence of auto safety restraint use (seat belts, child safety seats) for age groups (a) 0-11, (b) 12-18, and (c) >18.

* “Healthy days” are defined by CDC as days when an individual’s physical and mental health are reported to be good or better. A “Healthy Days Index” is calculated from four questions in the CDC behavioral risk factor surveillance system (BRFSS). (See MMWR. 47:12, p 239. April 3, 1998)

APPENDIX F:
Uniform Set(S) Of Nationally Aggregated Data

This appendix material is contained in a spreadsheet file “App F National DB.”

APPENDIX G:
Examples Of Successful Public Health Activities

Title of the Program: An Indian Community Health Profile Instrument

Contact: Dee Robertson, M.D., Director
Northwest Tribal Epidemiology Center (*The EpiCenter*)

Program Goal: Overcome the limitations of standard measures of health status, which largely are not useful for small communities, in order to provide meaningful guidelines to Indian communities wishing to assess their overall health.

Program Funding and/or Participant Sources:

Northwest Tribal Epidemiology Center
Indian Health Service
Headquarters East
Portland Area
Oklahoma Area
Two Northwest Tribes
Northwest Portland Area Indian Health Board
Oregon Health Sciences University School of Public Health
Centers for Disease Control
Other funding requests pending

Population Served: Specifically targeted to tribal communities of approximately 3000 to 5000 members, but potentially also useful for tribal communities both larger and smaller than this.

Public Health Services Provided: A brief, "user friendly" set of tribally and professionally reviewed data elements, covering multiple domains of health (e.g., dental, educational, medical, social) that can be successfully used by Indian communities to assess and monitor their overall health status. Unlike most of the "standard" measures of morbidity and mortality, these indicators are designed to be appropriate and valid for use in the "average" small Indian community. An important part of the services will also be technical assistance in implementing the system, and to the extent desired and feasible, assistance with analysis and design of appropriate interventions.

Outcomes of the Program: The set of Indian community health status indicators is now in its final stages of review and input. Measures of success will be how widespread its use becomes, and how useful it proves to be as a tool for communities in improving their health.

APPENDIX G:
Examples Of Successful Public Health Activities

Title of the Program: Center for Native American Health

Contact: James M. Galloway, M.D., Director

Program Goal: To develop a comprehensive health care and disease prevention resource for Native American communities that can be accessed by tribal and American Indian groups, either individually, or collectively. To assist tribes and urban programs to further develop their own capacity to deliver health care, to prevent disease, and promote health in an integrated fashion.

Program Funding Sources: University of Arizona, University Medical Center
Indian Health Service
Grants
Foundations

Advisory Board:

Tribal representatives
Urban Indian program representatives
Indian Health Service
State and Federal Agencies
Indian health organizations
University Medical Center and Arizona Health Science Center

Population Served: Southwest tribes and urban programs

Public Health Services Provided: Prevention Services and Evaluation
Community and Public Health Practice
Clinical Services
Health Career Pathways
Telemedicine
Health Systems Administration

Outcomes of the Program: Various. An example of a university centered organization created specifically to improve Native American health, through multi-organizational collaborations focused on meeting needs identified by Indian communities.

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Examples Of Successful Public Health Activities

Title of the Public Health Program: NICOA/Diabetes Program Data Project

Contact: Dave Baldrige, Director, NICOA; Drs. Kelly Acton and Stan Griffith.

Program goals: 1) See if useful diabetes outcome measurements can be performed on a national database aggregated from that information already being collected at local I/T/U facilities; 2) Integrate that data with data available from other federal agencies to expand its utility, enhance diabetes surveillance, and provide a more complete picture of diabetes and its complications in Indian people; 3) Provide meaningful data to tribes based on what they define as meaningful, in tribally-specific ways; 4) Accommodate all the various clinical information systems being used locally; 5) Develop a collaborative partnership with an national Indian organization to meet this need outside of IHS in the I/T/U setting.

Program Funding Sources: IHS Diabetes Program contracts (\$136,000 total) with additional IHS staff support from both the IHS Diabetes and Research Programs.

Population served: 5 pilot sites during the first year, with eventual expansion to all I/T/U sites nationally (and the populations they serve).

Public Health Services Provided: 1) Monitor health status to identify community health problems; 2) Investigate health problems and health hazards in the community; 3) Inform and educate people, communities, and Tribes about health issues; 4) Evaluate effectiveness, accessibility, and quality of personal and population-based health services.

Names of Participating Collaborating Agencies and Organizations: National Indian Council on Aging, Indian Health Service, HCFA, CDC, NCVHS, Bureau of Census, BIA, USGS, EPA.

Outcomes of the Program: Program is in its first year.

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Examples Of Successful Public Health Activities

Title of the Program: Northwest Portland Area Indian Health Board (NPAIHB)
Various Projects

These projects all preceded the recent creation of the Northwest Tribal Epidemiology Center, operated by the NPAIHB. They illustrate what may be accomplished by tribes joining together to employ public health oriented measures designed to improve the health of their members and their communities. Such efforts need not necessarily be based at an Area health board as these were, but could be effectively carried out by any strong tribal consortium or tribal organization with a public health mission.

Contact: Cheryle Kennedy, Executive Director
Northwest Portland Area Indian Health Board

Program Goal: Various. See below.

Program Funding Sources: Various. See below.

Population Served: 40 member tribes in the States of Washington, Oregon, and Idaho. (Occasional projects have had broader coverage.)

Public Health Services Provided & Outcomes:

- *Improving Health Data For Northwest American Indians* -- 19 Participating tribes provided access to tribal rolls, to allow matching with disease registries in order to reduce racial misclassification, and to facilitate obtaining tribal-specific health statistics.
- *Tribal Tobacco Policy Project* -- A collaborative effort involving the NPAIHB, the Oregon Research Institute, and Oregon State University. Followed by, *Western Tobacco Control Project* -- A cooperative agreement with NPAIHB, Alaska Native Health Board, and Montana-Wyoming Indian Health Board.
- *Hanford Tribal Service Program* -- Administered by the NPAIHB, this is a component of the Hanford Health Information Network, dealing with issues arising from the radiation releases over many years from the Hanford Nuclear Reservation.
- *Project Red Talon* -- A cooperative agreement with the Centers for Disease Control and Prevention, in order to provide training and technical assistance to Northwest tribes in the development of HIV/STD community prevention strategies.
- *Women's Health Promotion Program* -- A partnership with the Oregon Health Division to increase screening for breast and cervical cancer among Native American women.

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Title of the Public Health Program: Honoring Our Children with a Healthy Start

Contact: Dale Wolf, Deputy Director
Great Lakes Intertribal Consortium

Program Goal: To improve the health and well being of Native American children, families and communities through outreach and community education.

Program Funding Sources: Federal DHHS funding

Population Served: Tribal families at nine of the eleven Wisconsin Tribes have outreach and professional positions funded through this grant.

Public Health Services Provided:

- Development of stronger supportive networks for families through the active involvement of community members in service design and delivery.
- Improved access to health and human services for children and families.
- Greater public awareness of healthier lifestyle options.
- More opportunities for fathers and extended families to become involved in assuring the health and well being of mothers and children.

Outcome: We are in the first year of this grant. No outcomes to report yet.

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Examples Of Successful Public Health Activities

Title of the Public Health Program: Independent Study Modules for Community Health Nurse Interns/Trainees

Contact: Indian Health Service Division of Nursing

Program Goal: Provide a structured, consistent, self-paced orientation process for nurses new to the community health setting.

Program Funding Sources: These modules were developed through a contract Indian Health Service had with the University of Arizona.

Population Served: The population would include Community Health Nurses and their preceptors at federal, Tribal and Indian Urban sites.

Public Health Services Provided: These modules help to assure public health nursing competency .

Outcome: Self-paced community health nursing orientation modules are now available to local sites.

APPENDIX G:
Examples Of Successful Public Health Activities

Title of the Program: American Indian Health Delivery Plan
Tribal Public Health Jurisdictions

Contact: Joe Finkbonner
Lummi Nation

Program Goals: Develop, as mandated by the Washington State Legislature in the 1995 Public Health Improvement Act, with the assistance of an advisory group of American Indian and non-Indian health care providers and representatives of tribal, state, and local organizations, an American Indian Health Delivery Plan (RCW 43.70).

Program Partners: Sovereign Indian Nations in the State of Washington
Washington State Department of Health

Populations Served: Members of Washington State Tribes

Public Health Services Provided: Describe the public health needs of American Indians in the State of Washington, the resources available to help meet these needs, plans for changes that would be helpful in elevating the health status of tribal members, and strengthening tribal public health capacities. Help address the gap left by the statutory definition of Washington's public health system, which does not include tribes and their lands, by defining a new term, "Tribal Health Jurisdictions".

Outcomes of the Program:

The first edition of the American Indian Health Care Delivery Plan was completed two years ago, and the first update of this plan is now in its final stages. The American Indian Health Care Delivery Plan proposes for review the following definition of a tribal health jurisdiction:

A 'Tribal Health Jurisdiction' means the sovereign authority and power of a Tribe to perform public health services within the territories and the lands of the Tribe, and for all eligible tribal members regardless of where they reside; and shall include the authority to regulate all individuals within the Tribe's territories when the exercise of such authority is necessary to protect the health and welfare of tribal members or the Tribe's interest in maintaining public health.

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Title of the Public Health Program: Emergency Medical Services for Indian Health

Contact: Eric Broderick, D.D.S.
IHS Headquarters

Program goals: 1) Assure that Indian communities have access to high quality EMS; 2) Provide training and technical assistance to EMS providers serving AI/AN communities; 3) Promote increased access to EMS services

Program Funding Sources: The EMS program is funded primarily from the Hospitals and Clinics and Contract Health Services line items. EMS program expenditures in FY 1998 are estimated at approximately \$15,000,000.

Population served: About 500,000 American Indians and Alaska Natives receive EMS services from the approximately 70 EMS programs operated by IHS (2) and tribes (68).

Public Health Services Provided: 1) Monitor health status to determine EMS needs; 2) Investigate injury related problems in the community and promote injury prevention; 3) Collaborate with non-Indian EMS programs to make sure EMS services are available to the greatest extent possible to Indian people; 4) Collaborate with State and National EMS organizations on EMS standards; 5) Provide training for EMS providers; 6) Local providers conduct peer review of EMS services; Conduct descriptive studies for EMS needs in Indian country.

Names of Participating Collaborating Agencies and Organizations: National Native American EMS Association, Mountain Plains Health Consortium, Indian Health Service (National EMS Liaison, Area EMS Coordinators, EMS Medical Consultants, local EMS Medical Directors), Individual Tribal EMS Programs, State EMS Programs, and the Department of Transportation (NHTSA).

Outcomes of the Program:

What worked: Program effort is largely tribally initiated. A substantial amount of independence exists in the programs. There is strong ability in coalition building out of necessity. They are very creative in obtaining funding from whatever funding sources are available. They have strong support by the community.

What didn't work? Because of a lack of infrastructure, there is a lack of advocacy above the local level. There is a problem with fragmentation of support services for EMS programs. National advocacy has been person dependent at the national and regional levels.

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Examples Of Successful Public Health Activities

Title of the Public Health Program: AlaskaNet

Contact: Dick Mandsager, M.D.
Alaska Native Medical Center

Program goals: AlaskaNet is a formal not-for-profit consortium of Tribes in Alaska Area created to maintain: 1) Their purchasing power for medical care/services; 2) Their ability to negotiate reasonable reimbursement rates; 3) Their ability to market their services; 4) Their capability to compete for large grants and other outside funding.

Program Funding Sources: Unspecified contributions of resources from the Alaska Area Tribes.

Population served: All but 10 or 11 of the 226 Tribes in the Alaska Area.

Public Health Services Provided: 1) Mobilize community partnerships and coalitions to identify and solve health issues; 2) Develop policies and plans that support individual and community health efforts; 3) Link people to needed personal health services and assure the provision of health care when otherwise unavailable; 4) Assure a competent public health and personal health care workforce.

Names of Participating Collaborating Agencies and Organizations: Alaska Area Tribes, Robert Woods Johnson, DOD, Coast Guard, VA, Alaska BC&BS.

Outcomes of the Program: 1) Effectively competed for a CHIPs grant from Robert Woods Johnson; 2) ANMC, Kodiak, and Search are negotiating a PPO agreement with the DOD and Coast Guard; 3) ANMC has negotiated a PPO agreement with Alaska BC&BS; 4) Negotiating with Alaska Federal Health Partnership (Air Force, Army, Coast Guard, IHS, VA) to be included within their "buying cooperative."

APPENDIX G:

Examples Of Successful Public Health Activities

Title of the Public Health Program: Women, Infants & Children Special Nutrition Program (WIC) and Prenatal Care Coordination

Contact: Elaine Valliere, Project Director/WIC
Marti Hall, Project Director/Prenatal Care Coordination
Great Lakes Intertribal Consortium

Program Goal: WIC's goal program is to provide supplemental foods and nutrition education to lower income women, infants and children.

The Prenatal Care Coordination Program has the goal of improving the health and well being of prenatal women, their children and families.

Program Funding Sources: Funding for these programs comes through the State of Wisconsin Department of Health and Family Services.

Population Served: Nine of eleven Wisconsin Tribes are partners in these initiatives. The WIC program during fiscal year 1998 served an average of 1180 clients/month, at eleven Tribal sites. Each year the prenatal care coordination services approximately 200 women and 700 children birth to five.

Public Health Services Provided: Nutrition education, outreach for children birth to five and prenatal clients, well child checkups, and food vouchers are provided.

Outcomes of the Program: We have seen an increase in the percentage of pregnant women who begin prenatal care in their first trimester.

Fiscal Year	Number Pregnancies	Number Receiving Care 1 st Trimester	% Receiving Care 1 st Trimester
1994	279	121	43%
1995	324	226	70%
1996	313	235	76%
1997	332	256	77%

We have also seen the percentage of women initiating breast feeding and continuing breast feeding the first six months increase.

Fiscal Year	% Women Initiating Breast Feeding	% Women Continuing Breast Feeding 6 Mo.
1994	47%	18%
1995	52%	30%
1996	55%	56%
1997	56%	25%

APPENDIX H:
Factors For Success

Factors for Success	Organizational Involvement				
	<i>Tribal</i>	<i>Health Care Providers</i>	<i>Local Community</i>	<i>State/National</i>	<i>Non-government</i>
Baseline Needs Assessment					
Consultation Process					
Plan Based on Public Health Principles					
Communication Network					
Funding Resources/ In-kind Services					
History of Collaboration					
Process for Coalition Building					
Inclusion of All Shareholders					
Evaluation Plan					

**APPENDIX I:
DFEE Public Health Functions**

**Public Health Functions
Division of Facilities and Environmental Engineering¹**

- Health Care Facilities Construction
- Health Care Facilities Management
- Realty
- Clinical Engineering
- Sanitation Facilities Construction Program

Prevents Epidemics and the Spread of Disease

- Surveys and inventories the sanitation needs of American Indians and Alaska Natives (1)²
- Prioritizes the sanitation needs and develops projects based on health criteria, engineering data (5)
- Provides potable water facilities, wastewater disposal facilities, and solid waste disposal facilities and equipment for communities and individuals in collaboration and coordination with tribes and Federal, state and local agencies (4,7)
- Provides technical assistance and training to establish tribal programs and local codes for the safe and proper operation of drinking water and wastewater facilities (3,5,6)
- Coordinates with EPA, tribes, and states on all aspects of pollution prevention (2)
- Monitors/inspects environment (air, food, radiation, water, etc.) of health care facilities (1)
- Investigates waterborne disease outbreaks and tribal non-compliance with regulatory standards for drinking water (2)

Protects Against Environmental Hazards

- Assesses and re-mediate conditions in health care and other facilities to comply with environmental law/executive order (2)
- Investigates and coordinates the cleanup of environmental pollution events at the request of tribes (e.g., illegal hazardous waste dumping) (2)

Prevents Injuries

- Provides engineering support to the injury prevention specialists to analyze injury trends and develop intervention strategies. (5)
- Constructs/renovates facilities in conformance with American Disability Act (7)

¹ Does not include the IHS Environmental Health Program activities (typically performed by sanitarians) that fall under the Division of Community and Environmental Health

² Numbers in parentheses refers to which of the 10 essential public health functions this activity falls under.

APPENDIX I: DFEE Public Health Functions

Promotes and Encourages Healthy Behavior

- Provides homeowner training to promote the proper use of home plumbing for personal sanitation (3)
- Promotes drinking water fluoridation (3)

Responds to Disasters and Assists Communities in Recovery

- Provide engineering assistance in development of emergency response plans (regional/local) (2)
- Provides environmental health and engineering services to tribes and IHS locations when emergency events arise; coordinates response and recovery with local, state, and Federal agencies (2)
- Assesses environmental health and engineering needs arising from a Federally declared disaster; coordinates assignment of staff to address identified need under responsibilities in the Federal Response Plan (2)

Assures the Quality and Accessibility of Health Services

- Conducts life safety code surveys of all health care facilities operated by IHS, urban health, and tribes. (6, 9)
- Designs, constructs, and maintains facilities for the provision of health services (7)
- Monitors biomedical equipment for accuracy and effectiveness and repair as needed (7)
- Provide training and technical support to IHS and tribal environmental health and engineering staff (8)
- Sanitation program evaluations (9)
- JCAHO accreditation activities (9)

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